

ILLINOIS DEPARTMENT OF CORRECTIONS

Hill Correctional Center

Offender Outpatient Progress Notes

Offender Information:

Sheld
Last Name

Earnest
First Name

MI

ID#: 1366161

Date/Time	Subjective, Objective, Assessment	Plans
10/17/08	News leave time is now 7:45am.	
1:45p	R.O. + S.C. notified of chag. N. will ST	
10/22/08	RN note	
10:10A	Arrest Status Completed for	
	med furlough today	S. Valtanin
10/22/08	RN Note	
7:45AM	I/M left on med furlough	R Brown
7:45AM	Notified that returned from med furlough	R Brown
0:00AM	Informed by Ray Henry SA - that P.T. was refused I/M thought that he was having surgery for repair of pect. tear. To follow up c Staff MD R Brown	
10-26-08	MD visit	
3:40p	wt - 193.6 BB - 108/78	
10/26/08	P - 78 R - 18 T - 97.8 5' 38.1 years old Mr. Sheld will be ① Pectoral as tender, rupture of 11/6/08. informed patient that this will be due for	② DEXPHIC (MED) Mr. Sheld that it is important that he get the physical therapy as advised by M.D.
	continued	mylotan miglano?

Hill Correctional Center


Offender Information:

Shields
Last Name

Earnest
First Name

ID# B 666 60

M. 2.

Date/Time	Subjective, Objective, Assessment	Plans
10/26/68	Cartel, MD. U/W	
3:40	3rd visit for Physical Therapy. Patient reportedly saying that he is and will Refuse for physical therapy, and he wants surgery.	P,
	C/ - A/C 4; OR 3 - C/S Numb - C/A Numb - A/Care Bg - E/L - L2 Numb - A/	② Nursing Staff; if Mr. Sheld, Refer Refuse for Physical Therapy; please have him sign the refusal form and submit to me for review. Thank you.
3:58	LPN NOTE	
5:15A	I/A DECEASED HUNGEL STRIKE AT APPROX 0330A U/S TAKEN BR 100% PGO RIG & 4% AT THIS TIME	
		May Purchase [illegible]

2. Refusal
not bound

May. 25. 2010 1:55PM

SM

ILLINOIS DEPARTMENT OF CORRECTIONS

No. 2943

P. 26-28-08

Offender Health Status Transfer Summary

Transferring Facility:

1471 CC

Center

Offender Information:

Shelds

Last Name

Earnest

First Name

MI

ID#: B06601

Date: 10.27.08

Time:

6:45

☐ a.m. ☒ p.m.

Transfer Screening (completed by transferring facility health care staff):

☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies:

NKA

Food Handler Approved:

OK

Current / Acute Conditions / Problems:

Shoulder partial tendon rupture

Chronic Conditions / Problems:

G

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:

Pain in 800mg POTID X 7 days

Chronic Long-term:

G

Chronic Psychotropic:

G

Current Treatments:

G

Therapeutic Diets:

G

Follow-Up Care:

R&C

Chronic Clinics:

G

Specialty Referrals:

Physical therapy Cottage Rehab.

Significant Medical History:

G-SW of Foot and Ankle, depression

Physical Disabilities / Limitations:

G

Assistive Devices / Prosthetics:

G

Mental Health Issues:

☐ Hx Suicide Attempt Date: / /☒ Hx Psych Med☐ Hx MPC / STC

Substance Abuse:

☐ Alcohol ☐ Drugs☐ Power of Attorney

C. Montoya, RN

Print Name and Title

C. Montoya, RN

Signature

10.27.08

Date

Reception Screening (completed by receiving facility health care staff):

Facility:

Date: / /

Time:

☐ a.m.☐ p.m.

Objective:

Assessment:

Current Complaint:

Current Medications/Treatment:

Objective:

Physical Appearance/Behavior:

Deformities: Acute/Chronic:

T: P: R: B/P: /

Plan: Disposition:

☐ Health Information Given☐ Emergency Referral:☐ Sick Call: Urgent / Routine☐ Medication Evaluation☐ Therapeutic Diet☐ Special Housing☐ Chronic Clinics☐ Work / Program Limitation☐ Specialty Referrals☐ Other (specify):☐ Infirmary Placement:☐ HIV Test & Counseling Offered (only transfers from R&C)☐ Other (specify):

Printed Name and Title

Signature

Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility; Receiving Facility

DOC 0090 (Rev. 1/2008)

ILLINOIS DEPARTMENT OF CORRECTIONS
Medical Special Services Referral and Report

Offender's Name: Shelby, Ernest

(Facility)

ID# B6661

Reason for Referral:

- ☐ Consult ☐ Non-Formulary Medications ☐ Medical Equipment
☐ Evaluation ☐ Management
☐ Procedure/service (specify) _____
☒ Other (specify) _____

Urgent: ☐ Yes ☐ No

Referred to: Cottay Rehab & PT

Rationale for Referral: 3rd Visit for Physical Therapy

Print Referring Practitioner's Name

Referring Practitioner's Signature

Date

Findings: Report of Referral (Use Reverse Side, if necessary)
A continues to demonstrate obvious injury to the L per-
son o. apparent atrophy and distal tenderness/tightness in the L
per and muscle belly.

Assessment: The pt's PROM is unchanged compared to the
initial evaluation. ROM is not decreased compared to the
initial evaluation. The pt continues to do significant
pain to ROM strength today & pt's pain limited

Recommendations/Plans: The pt has not benefited from PT and has
been unable to progress toward pain relief and ROM goals
OK. PT at this time a further course of action re: pain injury
per the MD. The pt would benefit from eval by orthopedics MD if this
has not been done already.

Print Practitioner's Name: Jason Granlove

Practitioner's Signature: Jason Granlove PT

Date: 10/28/07

Facility Medical Director Use Only

I have reviewed the recommendations and:

☐ Approve.

☐ Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.

Print Facility Medical Director's Name

Facility Medical Director's Signature

Date

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

HILL

Center

Offender Information:

Shields

Ernest

ID#: B666161

Last Name

First Name

AD

TREATMENT PROTOCOL - MUSCLE PAIN/SPRAIN

Date/Time	Subjective, Objective, Assessment	Plans
11/19/08 2:45	S. What caused pain? Hx: Pectoral muscle tear (L)	P. MD referral
	Pain duration: Constant	(If any suspected fracture, difficulty walking, numbness, severe pain, swelling, deformity and/or fever).
	Location: (L) Pectoralis	
	Pain (1-10 most severe): 10/10	1. \$2 copay implemented due to inmate's request for non-emergency medical services.
	What precipitates pain? "When I lay down"	motrin 800mg TID x 10 days
	Alleviates pain? "Nothing"	No MD referral: (check as applicable):
	O. T P 82 R 20 BP 110/88	1. Ibuprofen 200 mg 2 tabs p.o. QID PRN x 3 days. 2. Cold compresses x 48 hours; then warm moist packs PRN.
	Appearance at rest: holds left neck	3. Elevate affected part. 4. Lay-in x 24 hours.
	Appearance with movement: full ROM, but pain exists	Patient teaching (check as applicable):
	Swelling: Y	1. Medication usage.
	Echymosis: Y	2. Use of cold/hot application.
	Redness: Y	3. Avoid weight lifting, sports or strenuous activity until area has healed and is free of pain (approx. 2 wks).
	Bruising: Y	4. Importance of body mechanics to avoid injury.
	Tenderness on touch: Y	5. Instruction regarding safety measures if injury, preventable, (warm-up exercises, etc.)
	Limited ROM: Y	6. Return if symptoms fail to resolve within 3 days or if symptoms worsen.
	Ankle Ottawa Rules	7. Complete Resident Injury Report form, if applicable.
	Knee Ottawa Rules	
	I'm c/o Dorsal numbness, but all sensation is present upon palpation	

ILLINOIS DEPARTMENT OF CORRECTIONS

Hill Correctional Center

Offender Outpatient Progress Notes

Offender Information:

Shields
Last Name

Ernest
First Name

MI ID# B66161

Date/Time	Subjective, Objective, Assessment	Plans
12-15-08 1:10p	LP Nnoti - NSC On NSC requesting to be taken off medical hold. Inmate did not want to be seen for NSC.	P-Refusal signed for refusing NSC @ this time. RIC: PRD S. [Signature]
12/17/08 2:30p	MD MUSE This pt has been evaluated By ortho + me Surgeon has been recommended to am. He has had PF to the extent that it will benefit him & the current status is his baseline. No further medical follow is planned.	P D/C medical hold [Signature] [Signature] [Signature] [Signature] [Signature]

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Health Status Transfer Summary

Transferring Facility:

Pulce Center

Offender Information:

Shields

Earnest

ID# B666161

Date: 1.12.09 Time: 1700 ☐ a.m. ☒ p.m.Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: NKDA Food Handler Approved: 2/28/08 yes

Current / Acute Conditions / Problems: \$

Chronic Conditions / Problems:

Current Medications (name, dosage, frequency, and duration):

Acute Short-term: \$

Chronic Long-term: \$

Chronic Psychotropic: \$

Current Treatments:

Therapeutic Diets: Regular

Follow-Up Care: RHC

Chronic Clinics:

Specialty Referrals:

Significant Medical History: No qsw @ Foot/Ankle No depression - @ meds

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics:

Mental Health Issues: ☐ Hx Suicide Attempt Date: / / ☐ Hx Psych Med ☐ Hx MPC / STC Substance Abuse: ☐ Alcohol ☐ DrugsR & C Use Only: ☐ LAB ☐ EKG ☐ CXR ☐ Dental ☐ MEDS ☐ MH ☐ Other: ☐ Packet Complete

H. Rethen

Print Name and Title

H. Rethen

Signature

1.12.09

Date

Reception Screening (completed by receiving facility health care staff):

Facility: SHCC

Subjective:

Current Complaint: Low m. made in @ arm

Current Medications/Treatment: \$

Objective:

Physical Appearance/Behavior: AOK3

Deformities: Acute/Chronic: \$

T: Not medically indicated

Shantal Buehler

Printed Name and Title

Shantal Buehler

Signature

1.14.9

Date

Date: 1.14.9 Time: 1630 ☐ a.m. ☒ p.m.

Assessment:

Open Sores (wound) @ arm
@ Charge @ arm
F. H. Approved

Plan/Disposition:

☒ Health Information Given ☐ Emergency Referral:☒ Sick Call: Urgent / Routine☐ Medication Evaluation ☐ Therapeutic Diet ☐ Special Housing ☐ Chronic Clinics☐ Work / Program Limitation ☐ Specialty Referrals ☐ Other (specify):☐ Infirmary Placement:☐ HIV Test & Counseling Offered (only transfers from R&C)☐ Other (specify):

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

PINCKNEYVILLE CORRECTIONAL Center

Stateville
Joliet

Offender Information:

Shields

Earnest

ID#: B10161

Last Name

First Name

M

Date/Time	Subjective, Objective, Assessment	Plans
3-3-09 2:00 PM	CMT Note Prisoner the show for MOSC will be recalled at 1:00 PM	
4/17/09	CMT NOTE	
11:30 A	S-I'm in pain all the time, they were supposed to do surgery on my shoulder (L) and they transfer me to A&D D3 & sugars of diabetes Evaluated 12/17/08 Surgery recommended refused 1/2 P.T. for Shoulder. requested medical Hold lifted last Inst so could transfer	P. F.U. PRN. Spoke to Dr. Ghosh motrin 800mg only D-Jaylin CMT

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

~~STP~~
PINKNEYVILLE CORRECTIONAL Center

Offender Information:

SHIELDS

Last Name

ERNEST

First Name

ID#: B66161

MI

Date/Time	Subjective, Objective, Assessment	Plans
4/28/09	1140 pm PA NOTE 36 y/o. Asian. my shoulder is torn bad, my chest is really torn up, I can't hardly do anything, they told me I need surgery. my (L) side goes numb. hard to sleep, I really tore up something, I might have a blood clot O = gen = incl. H = incl. Ext = (L) ant chest pect = undet atroph. flux to underarm. can't palp, R arm discomfort	1. Librium 750mg 2. B12 - 300 3. cont morphin 800mg as directed (has) 4. cont arm sling (has) 5. refer. to medical director for review/ evaluation 6. pt education / reassurance. noted by [signature] (signature)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

PINCKNEYVILLE CORRECTIONAL Center

Offender Information:

Shields

Ernest

1366167

Last Name

First Name

MI

ID#

Date/Time	Subjective, Objective, Assessment	Plans
5/1/9	MDMS.	
2:50P.	S- go injury to front of (L) chest in 7/2008 while lifting wt. 1/1M had fear of pectoralis muscle (L)	P. Orthoped. consult. Low back pain after until 8-31-9
	BP 114/77 P 67 T 97. WT 200 lbs.	Front cuffing problem until 8-31-9 Along problem until 8/31/9
	A - (L) BP 114/77 P 67 T 97 R 18 T 97.0	
	(L) pectoralis muscle was TA	
	Movement of (L) shoulder in in all directions.	
	A - (L) pectoralis fear	

pb/

ILLINOIS DEPARTMENT OF CORRECTIONS
Medical Special Services Referral and Report

2-19-13 M/B

Stateville Correctional Center

(Facility)

Offender's Name:

Shields Ernest

ID#

B66161

Reason for Referral:

☐ Consult

☐ Non-Formulary Medications

☐ Medical Equipment

☐ Evaluation

☐ Management

☐ Procedure/service (specify)

☐ Other (specify)

Urgent: ☐ Yes ☐ No

Referred to:

WIC Orthopedic

7/31/09

Rationale for Referral:

① pectoralis tear muscle rupture
on 7/2008.

Print Referring Practitioner's Name

P66161

Referring Practitioner's Signature

P661

Date

5/1/09

Findings:

① Pectoralis tear

Report of Referral (Use Reverse Side, if necessary)

no anterior muscle flap

Assessment:

① Pectoralis tear

chronic > 1yr

Recommendations/Plans:

Pt is too far out for surgical
intervention. He will need pain management
and physical therapy. Return as needed.

Print Referring Practitioner's Name

George Dzonde

Practitioner's Signature

George Dzonde

Date

7/31/09

Facility Medical Director Use Only

I have reviewed the recommendations and:

☒ Approve.

☐ Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision,
DOC 0255.

Print Facility Medical Director's Name

P66161

Facility Medical Director's Signature

P661

Date

8/3/09

OneRadiology

Normal, Illinois 61761

June 24, 2008

Patient Name: Shields, Ernest

Patient No# B66161

DOB: 2/19/71

Dr. Migliorino

Hill Correctional Center

LEFT SHOULDER TWO VIEWS 6/15/08

INDICATION: Pain.

FINDINGS: The views of left shoulder show no bony or soft tissue abnormality.

IMPRESSION: Normal left shoulder.

CHEST ONE VIEW 6/15/08

INDICATION: Pain.

FINDINGS: Lungs are clear. Heart is normal. Bony thorax is unremarkable.

IMPRESSION: Normal chest.

Signed _____

C. Lee, M.D.

DATE: 6/25/08
TIME REC: 1:00 pm
INITIAL DATE: CRN

CLieg

DIC: 6/24/08 Films from Hill Correctional Center

6/25/08
M

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Health Status Transfer Summary

Transferring Facility:

Stateville Correctional Center

Offender Information:

Shields

Last Name

Earnest

First Name

B66d61

ID#

Date: 7.31.09

Time:

1

☒ a.m. ☐ p.m.

Transfer Screening (completed by transferring facility health care staff):

Allergies: NRH

Food Handler Approved: _____

Current / Acute Conditions / Problems: /

Chronic Conditions / Problems: _____

Current Medications (name, dosage, frequency, and duration):

Acute Short-term: _____

Chronic Long-term: /Chronic Psychotropics: /

Current Treatments: _____

Therapeutic Diets: RegFollow-Up Care: Rxc

Chronic Clinics: _____

Specialty Referrals: u of ISignificant Medical History: GSW (2) foot & ankle

Physical Disabilities / Limitations: _____

Assistive Devices / Prosthetics: 1 bunk & gallyMental Health Issues: ☐ Hx Suicide Attempt Date: _____☐ Hx Psych Med ☐ Hx MPC / STC☐ Glasses☐ Dentures

R & O Use Only:

☐ LAB☐ EKG☐ CXR☐ Dental☐ MEDS☐ MH☐ Other: _____

Substance Abuse:

☐ Alcohol☐ Drugs☐ Packet Complete

Janet Stegall CRTB

Print Name and Title

Janet Stegall CRTB

Signature

7.31.09

Date

Reception Screening (completed by receiving facility health care staff):

Facility: _____

Subjective:

Current Complaint: _____

Current Medications/Treatment: _____

Objective:

Physical Appearance/Behavior: _____

Deformities: Acute/Chronic: _____

T: _____ P: _____ R: _____ B/P: _____

Printed Name and Title

Date: _____

Time: _____

☐ a.m.☐ p.m.

Assessment: _____

Plan: Disposition:

☐ Health Information Given☐ Emergency Referral:☐ Sick Call: Urgent / Routine☐ Medication Evaluation☐ Therapeutic Diet☐ Special Housing☐ Chronic Clinics☐ Work / Program Limitation☐ Specialty Referrals☐ Other (specify): _____☐ Infirmary Placement☐ Other (specify): _____

Signature

Date

For adult transition center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Stateville Correctional Center

Offender Information:

Strickland

Last Name

Carnest

First Name

ID#: B66161

MI

Date/Time	Subjective, Objective, Assessment	Plans
08-03-09 11-35A	MD not I/m was evaluated in the orthopedic clinic in the orthopedic clinic Impression: Torn R pectoralis muscle Not amenable to surgical repair	P No further F/H No medical hold / can transfer P6/2
8/29/9 9A	Pt c/o continued pain shoulder/chest. Not a surgical candidate. Wants permits renewed	Spoke to Med Dir - permit Renewal & consult Suggestor is W. A. H. 7
12/1/9	in DMK	
144/93	So my (R) elbow "popped"	Pt. sent x-ray
HR 88	10 days ago. it is out of place	(R) Elbow.
T 97	stick out on and off	
	U - DX 3/2/00 (R) Elbow no bruise seen.	
	A (R) Elbow injury	P2 DMK

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Stateville Correctional Center

Offender Information:

Shields		ID#:
Last Name	First Name	MI

Date/Time	Subjective, Objective, Assessment	Plans
12/1/9	MD NOTE	
12:50pm	S/O (R) Elbow x-ray shows ? avulsion fx of olecranon process. radiology report pending	Pl. case discussed w/ medical director. Permit for Low back brace cutting. No gym yet.
	Elbow No red no marked ecchyma no bruise.	Elbow brace and
	ROM guarded	Left arm s/dy given by medical director
	tender olecranon process	
	A (R) Elbow injury	2. may take Tylenol or 1100 for pain
	MD NOTE	Physician
12/3/9	S/O radiology report of (R) Elbow	
2:20pm	No Fracture. Small bone spur of olecranon process of proximal ulna.	Physician
	A (R) Elbow injury, patient not seen.	Pl. A/c as
	Fx pulled out by radiologist	pt request if symptoms persist

FOR X-RAY TECH ONLY

X-RAY REPORT

Reason for X-Ray: (R) Elbow stat.
S/R dislocation or strain 10 days ago.

Dr Zhang

Ordering Physician

Findings:

No fracture;
Small bone spur of olecranon process
of proximal ulna.

Date: _____

M.D.

FOR CORRECTIONAL CENTER HEALTH CARE UNIT PERSONNEL ONLY

☒ I have reviewed the recommendations contained in this report.

Date: 12/5/9

Signature and Title

Southern Illinois University - School Of Medicine
Scheduling System - Appointment Confirmation

Provider: OLYSAV, DAVID MD

EARNES DO340
ERNEST

Name: SHIELDS

Medrec Number: 820246

Address: 600 LINWOOD RD

Date Of Birth: 02/19/1971 37

C/O HENRY HILL CORR CTR

Sex: M

GALESBURG

IL 61401

Work Phone: 309-343-4212 373

Phone: 309-343-4212

Case: 0 OUTPATIENT

Where: SG SURGERY CLINIC 747-501

When: 08/26/08 at 09:00

Reason: 00 PECTORALIS RUPTURE

Comments: R/S D/T PER, DEB T FLG

PT. FILMS/PER EMAIL

Rpt To:

Ref Dr.:

INSTRUCTIONS

MMC OR STU FILMS BRING OUTSIDE FILM BRING INSURANCE CARDS AND COPAYS AT TIME
OF VISIT

Southern Illinois University - School Of Medicine
Scheduling System - Appointment Confirmation

Provider: OLYSAV, DAVID MD

D0340

Name: SHIELDS ERNEST
Address: 600 LINWOOD RD
C/O HENRY HILL CORR CTR
GALESBURG IL 61401
Phone: 309-343-4212

Medrec Number:
Date Of Birth: 02/19/1971 37
Sex: M
Work Phone: 309-343-4212 373

Case: O OUTPATIENT
Where: SG SURGERY CLINIC 747-501
When: 08/26/08 at 14:00
Reason: 00 PECTORALIS RUPTURE
Comments: PER EMAIL
Rpt To:

TO BG FILMS

RIS

Ref Dr.:

INSTRUCTIONS
MMC OR STJ FILMS BRING OUTSIDE FILM BRING INSURANCE CARDS AND COPAYS AT TIME
OF VISIT

SIU SCHOOL OF MEDICINE
DIVISION OF ORTHOPEDICS

MR# 820246

TO: NAME Natalie

LOCATION _____

FAX# 309 344-8547

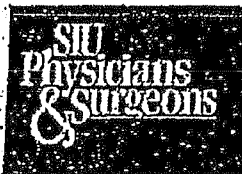
IMMEDIATE ACTION: _____ YES _____ NO

FROM: Nurses: X ce spoke with Dr. Oly saw he said it was O.K. to send pt for instructions for 2-3 visits with he can do P.T. on his own - call me with any questions

SIU School of Medicine
Department of Surgery
PO Box 19879
Springfield, IL 62794-9879

Clinic Operator: (217) 545-5878
Clinic Fax: (217) 545-1159

COMMENTS:



Date: _____

Name: Ernest Shields

Diagnosis: @ pectoralis major rupture

_____ Times per week for _____ weeks

_____ Evaluate & treat

Physical Therapy Program:

☐ Trunk flexibility and strengthening (McKenzie)

☐ ROM to _____

☒ Strengthening to aggressive @

☐ Aerobic conditioning

☐ Gait training

☐ Evaluation for _____

☐ Cervical spine isometric strengthening

☒ Other may instruct

for 2-3 visits

for home P.T.

Next clinic appointment _____

TRANSMISSI

PAGES SEI

Including this page

D. Oly saw
Physician Signature VORM

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SIU Physicians & Surgeons, Inc.
Department of Surgery
Outpatient Consult/New Outpatient Visit
David J. Olysav, M.D.

ENC: 30025035 FC: SG
PV: DO340 PS: SM
OLYSAV, DAVID MD
REF
PT: EARNEST
SHIELDS
MR# 820246 37 08/26/08
DOB 02/19/1971 09:00
CS: O 15041570019
INS W25 GUR
SOF: 08

Attending Physician
Referring Physician
Resource Code
Referring Service

CC: Rectovaginal rupture

NEW RETURN NEW PROBLEM

HISTORY PRESENT ILLNESS (HPI) Brief 1-3 * Ext ≥ 4 Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Assoc. signs & Sx

HPI (required)
Const in Calabazas
Bowel injury 6-18-08
500 lb press
+ numbness, right hand
+ all new - research

ROS	Prob Focus none	Exp Prob 1	Delayed 2-9	* Comp > 10 or some with "all others negative"
Constitutional	neg abn	GI	neg abn	Psychiatric neg abn
Eyes	neg abn	GU	neg abn	Endocrine neg abn
ENT	neg abn	Musculoskeletal	neg abn	Hematol/Lymph neg abn
Cardiovascular	neg abn	Skin	neg abn	Allergol/immun neg abn
Respiratory	neg abn	Neurologic	neg abn	ROS unobtainable
Other systems negative				

FF 90/150
AD 95/110
Ext 25 5/5
5/5 subcutaneous
5/5 int strength

* Past, Family, & Social History (PFSH) Pertinent = 1 from any 3, Complete = all 3

PAST MEDICAL HX:	FAMILY HX:	SOCIAL HX:	Occupation:
Unobtainable	Unobtainable	Unobtainable	Researcher
Non-contributory	Non-contributory	Non-contributory	
GENITURIN			
		Marital Status	M S D
		Children:	Y N
		Tobacco	Y N
		ETOH	Y N
		Quil	Y N
		Drug Use	Y N

MEDICATIONS:	Allergies: (Medication(s), Food, Metals, Other)
	LNKDA
	Past Surg Hx: ANKLE C BSW Hx of sexual trauma

Needs P.T.
for ROM & strength

① ② feet and heel
PT/OT for

①



Illinois
Department of
Corrections

Rod R. Blagojevich
Governor

Roger E. Walker Jr.
Director

Illinois Correctional Center / 800 Linwood Road / P.O. Box 1327 / Galesburg, IL 61401 / Telephone: (309) 343-4212 / TDD:
(800) 626-0844

MEMORANDUM

DATE: August 19, 2008
TO: Infirmary Staff
FROM: Lois Mathes, RN/HCUA

Medical Furlough has been scheduled as delineated below:

NAME: Shields, Earnest IDOC#: B66161 D.O.B: 2-19-71
DATE: 8-26-08 LEAVE TIME: 6:15 a.m.

REFERRING PHYSICIAN: Dr. Miglorino/Dr. Funk
REASON FOR FURLOUGH: Ortho. Eval. (Pectoralis Tendon Rupture Left Shoulder).

LOCATION: Dr. Olisav's Office
STREET: 747 N. Rutledge/Baylis Building 5th Floor
CITY/STATE/ZIP: Springfield, IL 62703
TELEPHONE NUMBER: (217) 545-5878

SAME DAY RETURN: X ADMISSION: EMERGENCY:
AMBULANCE:

1. Complete HS Report - Given to SA
2. MAR'S to Infirmary
3. Sign consent for TX/Operation Form
4. T.P./Admit to Infirmary

Prep Needed: Bring copies of all reports and x-ray film to appt. that is
pertaining to problem.

Cc: Records Office
7/3 Shift Commanders
Medical File
X-Ray
File

104 B66/61

Reason for Referral: ☒ Consult ☐ Non-Formulary Medications ☐ Medical Equipment
☐ Evaluation ☐ Management
☐ Procedure/service (specify) _____
☐ Other (specify) _____

Urgent: ☐ Yes ☐ No.

Urgent: ☐ Yes ☐ No.

Referred to: Dr. Olysa KIU Left Shoulder

Rationale for Referral: Ortho. Eval. (Pectoralis Tendon Rupture)

MIGLIAZZO
Print Register Practitioner's Name

Referring Practitioner's Signature

Date 2/24/88

Report of Referral (Use Reverse Side, if necessary)

Findings:

Approved By: David C.

Assessment

Light — 7 WYCS

Needs P.T. for Room & something

Recommendations/Plans:

P. T. @ Spalder
Room 5 Strongytherin

Print Practitioner's Name _____

Practitioner's Signature

Date _____

Facility Medical Director Use Only

I have reviewed the recommendations and:

☐ Approve.

☐ Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision.
DOC 0255.

Print Facility Medical Director's Name _____

Facility Medical Director's Signature

Date

[Wexford Health Sources]]

Subject: [Fwd: [Fwd: Wexford Health Sources]]
From: Lynn Singleton <lsingleton@slumed.edu>
Date: Fri, 22 Aug 2008 10:45:37 -0500
To: Janice Herman <jherman@slumed.edu>

REF ID:
DOS: 08/26/08 PV: DO340
MR#: 820246
PT: EARNEST
SHIELDS
DOB: 02/19/1971

----- Original Message -----
Subject: [Fwd: Wexford Health Sources]
Date: Tue, 19 Aug 2008 09:22:37 -0500
From: Judie Riech <jriech@slumed.edu>
To: Lynn Singleton <lsingleton@slumed.edu>

Lynn -- Forwarding e-mail sent to you last Friday. Just received a call from the Call Center saying they did not have authorization to make this appointment and transferred the call to me. Can you rectify? I have confirmed approval with correctional center for EARNEST SHIELDS, #B-66161 and asked them to call the CALL CENTER back in 30 minutes.
Thank you.

----- Original Message -----
Subject: Wexford Health Sources
Date: Fri, 15 Aug 2008 15:53:20 -0500
From: Judie Riech <jriech@slumed.edu>
To: Lynn Singleton <lsingleton@slumed.edu>, Cheryl McGill <cmcgill@slumed.edu>

SIU P&S has signed an agreement to provide medically necessary and authorized evaluation, treatment, and follow up care for the following:

Earneest Shields -- #B-66161 -- by Orthopaedic Surgery -- for Pectoralis Rupture

Original agreement is being forwarded to Patient Billing Services

Thank you,
Judie Riech
SIU P&S Admin. Office
545-BB50

8/22/2008 10:50 AM

June 30, 2010

EARNEST SHIELDS

MRN #: 820248

Home: (309)999-9999

Office: (309)343-

4212373

452216-2155001

Ins: WEXFORD (W25)

39 Years Old Male (DOB: 02/19/1971)

09/12/2008 - Phone Note

Provider: David J Olysav, MD

Location of Care: SIU HealthCare

Ok for PT to instruct 2-3 times for home PT per Dr. Olysav

Rx and note faxed to Natalie.

---- Converted from flag ----

---- 09/05/2008 4:25 PM, Katherine McMullin wrote:

Returned call and they had left already will return call again Monday am

---- 09/04/2008 2:08 PM, Katherine McMullin wrote:

---- 09/04/2008 1:55 PM, Beth Ann Peters wrote:

Is it for one time or does he have to go 2 to 3 times a week. Please call back by tomorrow, they need to know because he has collegial. Please call Natalie w/ Henry Hill Correction Center at 309-343-4212 ext 373 and she leaves at 4. Thanks

Clinical Lists Changes

Signed by Katherine McMullin on 09/12/2008 at 4:37 PM

Signed by David J Olysav, MD on 09/16/2008 at 7:57 AM

June 30, 2010

EARNST SHIELDS

4212373

39 Years Old Male (DOB: 02/19/1971)

MRN #: 820246

Home: (309)999-9999

Office: (309)343-

452216-2155001

Ins: WEXFORD (W25)

08/26/2008 - Transcription: EMDAT Clinic Note

Provider: John Froelich, M.D.

Location of Care: SIU HealthCare

EMDAT Clinic Note

CHIEF COMPLAINT: Left pectoralis major rupture.

HISTORY OF PRESENT ILLNESS: This is a 37-year-old gentleman who is a member of the Corrections Institution who was bench pressing on June 18, 2008, felt a sudden pain in his left arm and had a audible popping sound. Noted some numbness in his arm. He was evaluated in the local emergency room. Then MRI of the shoulder showed no significant injury other than a mild supraspinatus tear per a written documentation as the MRI is not here. He states that he continues to have numbness and night pain as well as discomfort. He had seen orthopedic surgeons who said they would not treat this injury on him. The patient is here for another opinion. He has not been doing any physical therapy or activity. He has been using a sling for sometime.

PAST MEDICAL HISTORY: History of meningitis as a child.

PAST SURGICAL HISTORY:

1. Repair of the left ankle after GSW.
2. History of multiple spinal taps.

MEDICATIONS: None.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

SOCIAL HISTORY: He is currently under the correctional system. Denies use of tobacco.

PHYSICAL EXAMINATION:

General: The patient is in no acute distress. Answers questions appropriately. Alert and oriented and appears stated age.

HEENT: Normocephalic, atraumatic. Gross extraocular movements are intact.

Cardiovascular: Regular.

Pulmonary: Unlabored.

Abdomen: Soft.

Musculoskeletal: Examination of the left shoulder shows no tenderness to palpation of the AC joint, the distal acromion, or the anterior biceps. He has forward flexion of 90 degrees active, passive 130 degrees, abduction active 75 degrees, passive 110 degrees, external 25 degrees active with 5-7 strength. He has 5/5 strength to the supraspinatus and 5-7 internal rotation. He is unable to get his arm to the back pocket position.

Digital examination of the shoulder shows palpable and visual defect in the pectoralis distribution. He is tender to palpation over the anterior chest with retraction of the pectoralis. When the patient does internally rotate the pectoralis does fire on his chest but in view there is a obvious palpable and visual defect and it does not insert on to the humerus at this time. There is no excessive swelling on that

EARNEST SHIELDS

MRN #: 820246

Home: (309)999-9999

Office: (309)343-

4212373

39 Years Old Male (DOB: 02/19/1971)

452216-2155001

Ins: WEXFORD (W25)

side versus the right.

IMAGING: MRI is not obtainable in the office today. The patient has plain films of the arm. Two views of the shoulder AP and oblique which show no fracture noted.

ASSESSMENT AND PLAN: This is a 37-year-old gentleman with a ruptured left pectoralis major. At this time, we will encourage the patient to do aggressive PT with strengthening as he has deconditioned the area as well as has lost range of motion in that arm.

Electronically Signed By:

John M. Froelich, M.D.

Resident

The following text was appended to the transcription:

I saw and personally examined the patient and discussed the case with the resident. I have reviewed the resident's note and agree with the content and plan as written except as follows: none.

Electronically Signed By:

David J. Olysav, M.D.

Associate Professor of Clinical Surgery

Signed before import by John Froelich, M.D.

Filed automatically on 09/02/2008 at 12:08 PM

Orthopedic Consult

SHIELDS, EARNEST - 80621578

* Final Report *

Result Type: Orthopedic Consult
Result Date: July 31, 2009 12:00 AM
Result Status: Modified
Result Title: Letter/Consultation- ATTENDING: Benjamin A Goldberg, MD
Performed By: Ozoude MD, George on July 31, 2009 7:52 PM
Verified By: Ozoude MD, George on August 03, 2009 6:26 AM

* Final Report * Document Contains Addenda

Letter/Consultation- ATTENDING: Benjamin A Goldberg, MD (Verified)
University of Illinois Medical Center at Chicago

LETTER/CONSULT

PATIENT: SHIELDS, EARNEST

DICT: GEORGE OZOUDE, MD
ATTNG: BENJAMIN A GOLDBERG, MD

MRN: 080621578
DATE OF SERVICE: 07/31/2009

July 31, 2009

RE: SHIELDS, EARNEST
MR# 080621578

SUBJECTIVE: This is a 36-year-old male who has had a longstanding left chest deformity from a torn pectoralis muscle. He injured it while lifting 375 pounds of a bench press bar. The patient has worsening pain that has not improved with medications for the past year. He has decreased function of the arm due to weakness.

OBJECTIVE: Decreased anterior axillary fold seen on exam. Weakness with internal rotation of the hand and arm compared to the right side. Gross deformity of the inferior aspect of the breast tissue.

ASSESSMENT AND PLAN: This is a 36-year-old male with a chronic torn pectoralis muscle. The patient was seen by several different orthopedic surgeons in the past year, all of which have determined that they do not do that type of surgery. The patient presented to us on this day with chronic tear that is not amenable to surgical repair. The patient was upset with the decision making. He was explained that his condition was not amenable to

Printed by: Rodriguez, Yolanda
Printed on: 5/6/2010 2:40 PM

Page 1 of 2
(Continued)

Orthopedic Consult

SHIELDS, EARNEST - 80621578

* Final Report *

repair, however, he could explore the option of cosmetic intervention. We further explained that there would be no further function gained if we were to go ahead and repair the pectoralis muscle. The patient verbalized understanding of the assessment and plan. The patient was seen and discussed with Dr. Goldberg who agrees with assessment and plan.

Benjamin A Goldberg, MD

George Ozoude, MD

DD: 07/31/2009 19:52:58

DT: 08/02/2009 21:37:06

GO/MedQ

JOB: 819147/382047969

Addendum by Goldberg MD, Benjamin on August 07, 2009 12:44 PM (Verified)

I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note

Completed Action List:

- * Perform by Ozoude MD, George on July 31, 2009 7:52 PM
- * Transcribe by on August 02, 2009 9:37 PM
- * Sign by Ozoude MD, George on August 03, 2009 6:26 AM Requested on July 31, 2009 7:52 PM
- * VERIFY by Ozoude MD, George on August 03, 2009 6:26 AM
- * Sign by Goldberg MD, Benjamin on August 07, 2009 12:44 PM Requested by Ozoude MD, George on August 03, 2009 6:26 AM
- * Modify by Goldberg MD, Benjamin on August 07, 2009 12:44 PM

Printed by: Rodriquez , Yolanda
Printed on: 5/6/2010 2:40 PM

Page 2 of 2
(End of Report)

ILLINOIS DEPARTMENT OF CORRECTIONS
Medical Special Services Referral and Report

Offender's Name:

Shields, Ernest

ID#

B66/61

Reason for Referral:

☐ Consult

☐ Non-Formulary Medications

☐ Medical Equipment

☒ Evaluation

☐ Management

☐ Procedure/service (specify) _____

☐ Other (specify) _____

Urgent: ☐ Yes ☐ No

Referred to:

Dr. Scherer

Rationale for Referral:

Left Shoulder Injury Eval.

Print Referring Practitioner's Name

Referring Practitioner's Signature

Date

Findings:

Ruptured

Report of Referral (Use Reverse Side, if necessary)

(L)

pectoralis

tendon

Assessment:

Ruptured

(L)

pectoralis

tendon

Recommendations/Plans:

Needs to see shoulder
specialist. report to follow

Print Practitioner's Name

Practitioner's Signature

Date

Scherer

[Signature]

6/23/08

Facility Medical Director Use Only

I have reviewed the recommendations and:

☐ Approve.

☐ Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.

Print Facility Medical Director's Name

Facility Medical Director's Signature

Date

June 23, 2008

Henry Hill Correctional Center

Dr. Shute

600 Linwood Road

Galesburg, IL 61401

REF: EARNEST SHIELDS

Dear Dr. Shute;

Enclosed are my office notes of 06/23/08 concerning Earnest Shields. He has a pectoralis tendon rupture of the left chest and shoulder. He needs to see a shoulder specialist for surgery. I have not performed this surgery in the past.

If you have any questions, please contact me.

Sincerely,

Gregory A. Schierer, M.D.

GAS/jlh

Enclosure

06/23/08 EARNEST SHIELDS 111453.0

This 34 year old is a prisoner at Henry Hill Correctional Center. He was lifting weights on 06/18/08 when a weight dropped and he injured his left chest. He felt something snap. He has had ecchymosis of the left proximal humeral area and lateral chest near the axilla on the left side. He is complaining of constant pain, worse with activity.

Past Medical History: The patient has had a gunshot wound in the past.

Medications: Motrin.

Allergies: None.

Family History: Not contributory to this problem.

Social History: Habits: tobacco and alcohol - none. The patient is a prisoner.

Review of Systems: No other complaints voiced.

Physical Examination: The patient is 5'8" and weighs 185 pounds. The left shoulder shows ecchymosis of the proximal humerus and the axilla. There is tenderness of the pectoralis insertion. There is an obvious rupture of the pectoralis tendon. The patient has weakness of adduction of the left shoulder. He has pain with passive abduction.

Assessment: Pectoralis tendon rupture left shoulder.

Plan: This injury requires treatment by a shoulder specialist. I do not

have the expertise to perform the surgery necessary to treat this problem.

Gregory A. Schierer, M.D./jlh

ORTHOPEDIC INITIAL HISTORY

☐ WC

☐ INS

☐ LIAB

☐ IME

Date 6/23/08 Patient EARNEST SHIELDS Acct # _____ Phone 343-4212

Age 34 ☒ M ☐ F Height 5'8" Weight 185 B/P 1 Pulse _____

Did you bring : X-RAYS ☐ MRI ☐ ESI ☐ CT ☐ EMG ☐ BONESCAN ☐ Other _____

Who requested you visit this office ? Doctor SHUTE + FURK Attorney _____ Self-Referral ☐

What is the main reason for this visit? Pain ☐ Numbness ☐ Weakness ☐ Other ☐

Neck	Shoulder	L <input checked="" type="checkbox"/> R <input type="checkbox"/>	Elbow	L <input type="checkbox"/> R <input type="checkbox"/>	Hand	L <input type="checkbox"/> R <input type="checkbox"/>	Pelvis	L <input type="checkbox"/> R <input type="checkbox"/>	Knee	L <input type="checkbox"/> R <input type="checkbox"/>	Foot	L <input type="checkbox"/> R <input type="checkbox"/>
Back	Arm	L <input type="checkbox"/> R <input type="checkbox"/>	Wrist	L <input type="checkbox"/> R <input type="checkbox"/>	Finger	L <input type="checkbox"/> R <input type="checkbox"/>	Hip	L <input type="checkbox"/> R <input type="checkbox"/>	Ankle	L <input type="checkbox"/> R <input type="checkbox"/>	Toe	L <input type="checkbox"/> R <input type="checkbox"/>

How long has this problem been present? _____ Occupation _____ Emplr _____ Status _____

How did your problem start:

- No Injury ☐
- Gradual or sudden ☐
- Injury - Other ☒ LIFTING AND DROPPED WEIGHTS
- Where and how ☐
- Injury at work ☐
- Where and how ☐
- Work Related but no injury ☐
- How did job cause problem ☐
- Auto Accident ☐
- Where and how ☐

Please describe	Date of occurrence
<u>LIFTING AND DROPPED WEIGHTS</u>	<u>6/18/08</u>

The pain is ☒ Constant ☐ Comes and goes _____

Severity of pain ☐ Mild ☐ Moderate ☒ Severe ☐ Extremely Severe

Quality of pain ☒ Sharp ☐ Dull ☒ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other _____

Associated Symptoms ☒ Swelling ☐ Numbness ☐ Weakness ☐ Other _____
☒ Popping ☐ Grinding ☐ Catching

Since the problem started ☐ Better ☐ Worse ☒ Unchanged Does the pain wake you from sleep ☒ Y ☐ N

What makes the symptoms worse? ☒ Activity ☐ Exercise ☐ Work ☐ Stairs ☐ Other _____

Which make you feel better? ☒ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _____

What medications have you taken or been prescribed for this condition? MOTRIN

What Treatments have you tried? ☐ Injections ☒ Brace ☐ Therapy ☐ Cane/Crutch ☐ Other _____

What Pharmacy do you use? Name: _____ Phone: _____
 Address: _____ Zip: _____

Place of Service: GOS _____ MONMOUTH _____ ALEDO _____ MACOMB _____

REVIEW OF SYMPTOMS: Do you have now, or have you ever had, any of the following health problems?

1) M/S Have you had a prior problem with this same Orthopedic condition in the past Y ☒ N (explain below)

Have you had any prior ☐ back pain ☐ joint swelling ☐ fracture ☐ arthritis

2) ARE YOU ALLERGIC TO ANY MEDICATIONS Y ☒ N If yes please list

3) ARE YOU A DIABETIC? Y ☒ N TREATMENT: ☐ Insulin ☐ Oral meds ☐ Diet ☐ None

		NONE	YEAR	EXPLAIN DETAIL
4) CON	weight loss loss of appetite fever cancer	<input checked="" type="checkbox"/>		
5) EYE	<u>glasses</u> Contacts Double vision Cataract	<input type="checkbox"/>		
6) ENT	hearing loss Hoarseness Ringing in ears	<input checked="" type="checkbox"/>		
7) CV	high blood pressure Heart attack blood clots	<input checked="" type="checkbox"/>		
8) RS	asthma cough pneumonia SOB TB	<input checked="" type="checkbox"/>		
9) GI	stomach ulcer hepatitis blood in stool	<input checked="" type="checkbox"/>		
10) GU	pain w/ urination blood in urine kidney disease	<input checked="" type="checkbox"/>		
11) SK	skin ulcers rash lumps	<input checked="" type="checkbox"/>		
12) NEU	seizures stroke balance prob headaches	<input checked="" type="checkbox"/>		
13) PSY	depression nervousness sleep disorder	<input checked="" type="checkbox"/>		
14) HEM	easy bleeding easy bruising anemia	<input checked="" type="checkbox"/>		

PAST MEDICAL HISTORY

What medications do you take? ☐ None Please list w/dosage MOTRIN + PAIN PILLS

Are you taking or have you ever taken blood thinners? Y ☒ N If yes, what type

Past surgical history: What operations have you had? ANKLE + LOWER BACK - GUN SHOT

Have you ever had a reaction to anesthesia? Y ☐ N

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative

Any direct relative with the same Orthopedic condition you are being seen for today Y ☐ N
 Diabetes Y ☐ N High blood pressure Y ☐ N Heart disease Y ☐ N Arthritis Y ☐ N Cancer Y ☐ N

SOCIAL HISTORY:

Do you use tobacco? Y ☐ N Alcohol use? Y ☐ N How often? ☐ Daily ☐ Weekly

Marital History: ☐ M ☐ S ☐ D ☐ W How many people live with you? 1

ASSESSMENT

State should be

PLAN

Sub

Nurse

Doctor

date

date

Galesburg Cottage Hospital
695 N. Kellogg St.
Galesburg, IL 61401

Patient Name:	SHIELDS, EARNEST D	Room Number:	EOP
Medical Record #:	418894	Patient Number:	5290082
Date of Service:	06/16/2008	DOB/SEX:	2/19/1971 / M
Ordering Physician:	BOMMIASAMY VEERASIKKU MD	Admitting Physician:	BOMMIASAMY VEERASIKKU MD

RADIOLOGY REPORT
MAGNETIC RESONANCE IMAGING OF THE LEFT SHOULDER

HISTORY: The patient was weight-lifting today and heard a "pop" resulting in limited range of motion and pain in the shoulder joint.

TECHNIQUE: Sequences as listed.

FINDINGS: There is moderate increase in signal intensity within the distal supraspinatus - rotator cuff tendon, compatible with moderate tendinosis and/or partial tear. There was no abnormal fluid within the glenohumeral joint or subacromial - subdeltoid bursa. The glenoid labrum appears intact. Marrow space signal intensity of the visualized humeral head and glenoid process appear within normal limits. The bicipital tendon appeared within the bicipital groove.

SUMMARY:

**MODERATE TENDINOSIS AND/OR PARTIAL THICKNESS TEAR SUPRASPINATUS - ROTATOR CUFF TENDON.
MILD DEGENERATIVE CHANGES LEFT ACROMIOCLAVICULAR JOINT WITH MINIMAL INDENTATION ON THE
ROTATOR CUFF MUSCULOTENDINOUS STRUCTURES.**

STEPHEN LEHNERT MD

Electronically Signed on 6/17/2008 1:40 PM by Stephen Lehnert, MD

RADIOLOGY REPORT

DD: 6/17/2008 11:02

TT: 6/17/2008 11:38

Printed At: 6/20/2008 11:08

SL / 639

Page 1 Of 1

Job #: 2754135

MANUALLY PRINTED BY USER

72



Jun. 16. 2008 6:09PM Radiology

STEPHEN LEHNER, MD

No. 5050 P. 1 01/01
No. 5047 P. 2

Jun. 16. 2008 5:53PM RL logy, Stage Hospital

Number: 5290082
Name: SHIELDS, EARNEST D
Rm/Bed: O/P / ROP
Admit: 6/16/08
Dx: SHOULDER INJURY
Sx/Rx: M-B
DOB: 2/19/71
Age: 37
Rt/Wt:
Chart#: 418894

Ordering Dpt: RAD
Order Dt/Tm: 6/16/08 17:04
Order Status: ROUTINE
Start Dt/Tm: 6/16/08 17:04
Keyed By: CST/MOPS
Order Phys: DOMINIC VERRASIKK
Admit Phys: DOMINIC VERRASIKK
Primary Phys:
Jacket #

TRANSPORT: WALK
IV/O2?: NONE
LMP?: NA
SE?: E/C7 EE



000418894

Last Exam Date:


200 MR-UPPER EXTREMITY

COMPLETE MR SAFETY FORM
Pain

RIDE: LEFT ISOLATION NONE

*annate weight lifting
heard POP
Limited ROM
Severe pain in joint.*

*MR1 (L) shoulder - moderate tendinosis
or partial tear supraspinatus tendon*

otherwise 

L. Lehner, MD

JUN 16 PM 05

O.P. NUMBER

DATE

**Galesburg Cottage Hospital**

695 N. Kellogg St. • Galesburg, IL 61401 • 309-343-8131

FOLLOW-UP INSTRUCTIONS

- ☐ Follow-up & Re-evaluation in _____ Hours, _____ days, _____ weeks.
☐ Call for appointment.
☐ Appointment has been made for _____ for
PHYSICIAN DR. STACHATIN
ADDRESS _____
PHONE 6-16-09
☐ OP Tests _____

- ☐ Call your MD's office in 72 hours for your final culture report.
☐ X-rays do not always show injury or disease, and fractures may not be revealed on the initial x-rays. If the problem persists or worsens, additional x-rays or tests may be required. If this occurs, you should contact your physician or return to the ER. Your initial x-ray reading is a preliminary report. The radiologist will make a final reading. You will be informed if there is any significant difference from the preliminary reading.
☐ For Workman's Compensation patients see company MD within 24 hours for follow-up.
☒ The physician services in the Galesburg Cottage Hospital Emergency Department are provided by Advanced Emergency Specialists, an independent contractor. The physicians comprising this group are not agents or employees of Cottage Hospital. The examination and treatment you have received in the Emergency Department has been rendered on an emergency basis only, and is not intended to be a substitute for, nor an effort to provide complete medical care. Because it is impossible to recognize and treat all elements of an injury or illness in a single emergency visit, it is important that you follow-up with your physician or the referral physician for your safety. Follow the instructions outlined below. If your present condition persists or worsens please contact the physician listed below. If unable to contact this physician you may return to the Emergency Department at any time.

PROVISIONAL DIAGNOSIS

ROTATOR CUP JOINT
DR. STACHATIN

OTHER SPECIFIC INSTRUCTIONS:

SLING
Ice pack
Keep PT at home

IT IS VERY IMPORTANT FOR YOU TO FOLLOW-UP AS DIRECTED, ESPECIALLY IF YOUR CONDITION PERSISTS, OR WORSENS, OR YOU DEVELOP NEW SYMPTOMS.

I HEREBY ACKNOWLEDGE RECEIPT OF AND UNDERSTAND THE PRINTED AND VERBAL INSTRUCTIONS.

X Emory Hill

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON

SIGNATURE OF NURSE

GENERAL INSTRUCTIONS

- Persistent pain or disability for more than 72 hours are caution signs; notify your physician for further evaluation.
☐ Your eye has been patched. Please remove the patch in _____ hours. DO NOT DRIVE, as your ability to perceive depth will be impaired and your field of vision restricted.
☐ Ace/Splint
☐ Keep injured part at rest and elevated as much as possible.
☐ Ice intermittently to injured area for 24 hours. (On for 20 minutes then off for 20 minutes, etc.) Place cloth between ice bag to protect skin.
☐ Use heat.
☐ No weight bearing until okayed by your own physician, use crutches as directed.

MEDICATIONS

- ☐ Medications per reconciliation process.
☐ Due to medication you have been given in the emergency department, your alertness may be impaired and you may be drowsy. Do not drive, operate potentially dangerous machinery, or climb heights for 8 hours.
☐ Ibuprofen (Motrin, Advil) Adults: _____ milligrams, # _____ every _____ hours. Please stop ibuprofen if you should develop abdominal pain, blood in your stools or black stools. DO NOT USE IF ALLERGIC.
☐ Acetaminophen (Tylenol) Adults: _____ milligrams, # _____ every _____ hours. DO NOT USE IF ALLERGIC.
☐ _____
☐ _____

WOUND CARE INSTRUCTIONS

- Follow-up with your own MD within 1 to 2 days for wound check. Call for appointment.
☐ Keep dressing clean and dry.
☐ Observe for signs of possible infection which include:
Redness, swelling, heat, red streaks, pus and/or drainage, increased pain, unexplained fever. CONTACT YOUR DOCTOR IMMEDIATELY IF THESE OCCUR.
☐ Arrange for suture removal in _____ days.

SPECIAL CARE INSTRUCTIONS

- ☐ Drink lots of cool fluids, water and juices etc. # Ounces _____ Per _____
☐ Take temperature every 2 - 4 hours.
☐ Extra rest.
☐ Call physician immediately if seizures or convulsions occur or if a rash develops.

OTHER FOLLOW-UP

- | | | |
|--|---|--|
| <input type="checkbox"/> Colds/flu, sore throat, cough | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Otitis Media Sheet |
| <input type="checkbox"/> Orthopedic injury care | <input type="checkbox"/> Back pain | <input type="checkbox"/> Animal Bite Sheet |
| <input type="checkbox"/> STD instructions | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Immunization Card Given |
| <input type="checkbox"/> Burn Care | <input type="checkbox"/> Heat and Cold emergencies | |
| <input type="checkbox"/> Respiratory care, croup, asthma | <input type="checkbox"/> Vomiting/diarrhea in adults | |
| <input type="checkbox"/> Fever care instructions | <input type="checkbox"/> Urinary tract infection | |
| <input type="checkbox"/> Head injury Sheet | <input type="checkbox"/> Bites | |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> General pediatric instructions | |
| <input type="checkbox"/> Post Nosebleed Information | <input type="checkbox"/> Fever/Med Sheet | |

Form # 8600173 (Rev. 5/00)

Galesburg Cottage Hospital
309-343-8131

695 N. Kellogg St.
Galesburg, IL 61401

Galesburg Cottage Hospital
309-343-8131

695 N. Kellogg St.
Galesburg, IL 61401

FOR

DATE

ADDRESS

Rx

FOR _____ DATE _____

The above was seen, treated, and released from our Emergency Department. I recommend:

- ☐ Release from usual/all employment responsibilities for _____ days.
☐ Release from participation in school classes/physical education / athletics for _____ days.
☐ Immediate return to work/school.
☐ Restrictions: _____

M.D.

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Health Status Transfer Summary

Med. Junk
6-23-08
27-7:15am

Transferring Facility:

HH C

Center

Offender Information:

Shields
Last Name

Emmett
First Name

MI

ID#:

B66/4

Date: 6/11/08

Time:

1425

☐ a.m. ☒ p.m.

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies:

N/A

Food Handler Approved:

2-16-08 Yes

Current / Acute Conditions / Problems:

end of R shoulder injury

Chronic Conditions / Problems:

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:

Motrin 800mg TID PRN 4/1 7/19/05

Chronic Long-term:

Chronic Psychotropic:

Current Treatments:

4

Therapeutic Diets:

Gen

Follow-Up Care:

per ortho

Chronic Clinics:

4

Specialty Referrals:

ortho

Significant Medical History:

2001 GSW (D) to forehead

Physical Disabilities / Limitations:

4

Assistive Devices / Prosthetics:

4

☐ Glasses

☐ Dentures

Mental Health Issues:

☐ Hx Suicide Attempt: Date: / /

☐ Hx Psych Med

☐ Hx MPC / STC

Substance Abuse:

☐ Alcohol

☐ Drugs

R & C Use Only:

☐ LAB

☐ EKG

☐ CXR

☐ Dental

☐ MEDS

☐ IMH

☐ Other:

☐ Packet Complete

Leda Parish RN

Print Name and Title

MM

Signature

6/29/08

Date

Reception Screening (completed by receiving facility health care staff):

Facility:

Date:

Time:

☐ a.m.

☐ p.m.

Subjective:

Assessment:

Current Complaint:

Current Medications/Treatment:

Objective:

Physical Appearance/Behavior:

Deformities: Acute/Chronic:

T: P: R: B/P: /

Plan: Disposition:

☐ Health Information Given

☐ Emergency Referral:

☐ Sick Call: Urgent / Routine

☐ Medication Evaluation

☐ Therapeutic Diet

☐ Special Housing

☐ Chronic Clinics

☐ Work / Program Limitation

☐ Specialty Referrals

☐ Other (specify):

☐ Infirmary Placement:

☐ HIV Test & Counseling Offered (only transfers from R&C)

☐ Other (specify):

Printed Name and Title

Signature

Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

NEW PATIENT INFORMATION GALESBURG ORTHOPEDIC SERVICES, LTD

Date 6/23/08
 Patient Name Ernest Shields Driver's License # _____
 Street 600 Lenwood City Galesburg
 State IL Zip 61401 Employer _____
 Home Phone 343-4212 SS# _____ Work Phone _____
 Date of Birth 2-19-42
 Emergency Contact Mother JoAnn Shields
 Relationship Mother Phone # (773) 464-2971
 Spouse's Name Shields SS # _____ Employer _____
 Family Physician _____
 Were you referred by a physician? Who? DR. SHUTE / DR. FUNK

If Minor, responsible party and address _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Medicare/Public Aid # _____

Name of Commercial Group Ins: _____

Address _____

Ins Co Phone # _____

Insured's Name _____

Insured's SS # _____

Insured's Date of Birth: _____

Group Number: _____

Effective Date _____

Insured's Employer Name and Address: _____

SECONDARY INSURANCE

Medicare/Public Aid # _____

Name of Commercial Secondary Ins: _____

Address _____

Ins Co Phone # _____

Insured's Name _____

Insured's SS # _____

Insured's Date of Birth: _____

Group Number: _____

Effective Date: _____

Insured's Employer Name and Address: _____

WORK INJURY ONLY: (please answer all questions)

Date of Workcomp injury or first symptoms occurred _____

How accident happened _____

Have you ever had same or similar condition? Y / N If yes, state when and

Describe _____

Currently Working? Y / N If No, date first disabled _____

Have you filed a claim with your employer? Y / N Claim Number _____

Name and address of Workers comp insurance to be billed _____

LIABILITY OR AUTO INJURY ONLY:

Date of injury or first symptom occurred _____

How did accident happen _____

Are you currently working Y / N Name and address of party involved _____

Name and address of insurance to be billed _____

Policy and Claim Numbers _____

ATTORNEY INFORMATION, if any _____

Welcome and Thank you for choosing Galesburg Orthopedics

Galesburg Orthopedic Services, Ltd.

FINANCIAL POLICY

Thank you for choosing Galesburg Orthopedic Services, Ltd. for your healthcare needs. The following information describes our financial policy and information about our billing and insurance services. This form must be read and signed prior to treatment.

Private Insurance / Medicare-Medicaid / Managed Care: As a courtesy to our patients your charges will be filed with your insurance company. All co-pay and deductible amounts must be paid at the time of service. You must provide a current and valid insurance card and all applicable information pertaining to your claim. We accept Medicare Assignment and will file with Medicare and your secondary insurance on your behalf. If you are a member of a managed care plan, it is your responsibility to verify our participation in your network and that any necessary referrals and precertifications are completed. Balances over 60 days past due will become the responsibility of the patient and you will be billed directly. We reserve the right to accept or deny assignment of insurance benefits. We accept cash, check, Visa and MasterCard.

Workers Compensation / Accidents / Personal Injury: If you are being seen due to a work related injury, an accident or injury where another party is liable, your claims will be filed with the applicable insurance carrier. You must provide all pertinent insurance information including employer, claim number and the claim adjusters contact information. We will also ask you to provide your health insurance information. In the event your claim is denied or delayed, your claim will be filed with your group health insurance. If your injury becomes a legal matter and payment is further delayed you will be billed directly and responsible for payment of all unpaid balances.

Returned Check Fee / Collection Costs: You agree to pay a \$25.00 service charge on all return checks. You also acknowledge that you are fully responsible for the payment of all services provided. If your account is assigned to an attorney or collection agency for failure to pay, you will be responsible for the cost of collection, court costs and any reasonable attorney fees.

By signing below you affirm that you have read and understand our **Financial Policy** and that you agree to its contents.

Ernest Shields
Signature of patient or responsible party

6/23/08
Date

ASSIGNMENT OF BENEFITS

In consideration of these medical services, I hereby assign, transfer and set over to Galesburg Orthopedic Services, Ltd. all my rights, title and interest to medical reimbursement benefits under my insurance policy(s). A photocopy of this Assignment is to be considered as valid as an original. This Assignment will remain in effect until revoked by me in writing.

Ernest Shields
Signature of patient or responsible party

6/23/08
Date

CONSENT FOR RELEASE AND USE OF INFORMATION AND RECEIPT OF PRIVACY NOTICE

I, hereby give my consent to Galesburg Orthopedic Services, Ltd. to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of Ernest Shields
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in this Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me by giving written notice to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

Ernest Shields
Signature of patient or responsible party

6/23/08
Date

201 South Grand Avenue East
Springfield, Illinois 62763-0001

201 South Grand Avenue East
Springfield, Illinois 62763-0001

Telephone: (217) 785-0710
TTY: (217) 521-5012

201 South Grand Avenue East
Springfield, Illinois 62763-0001

DATE:

TO: Participating Hospitals; Chief Executive Officers, Chief Financial Officers, and Patient Accounts Managers; and Physicians

RE: Medical Services Provided to IDOC Inmates.

Effective Dec. 17, 2005, hospital providers should direct bill HFS for certain hospital services provided to inmates at IDOC facilities. These services include all Categories of service 20, 22, 24 and 29. It is the intent of HFS and IDOC to allow hospital providers to submit bills in accordance with current billing practices as outlined in the hospital handbook. Until such time as system changes are in place we are requesting that hospital providers submit bills for services rendered to IDOC inmates via the hardcopy (UB-92) method outlined in the hospital handbook.

We are requesting that when a bill is prepared, the bottom portion of this document accompanies the bill to allow HFS staff to identify and handle these claims appropriately. In the event that an HFS RIN is not available at the time of billing, please submit the fully completed hardcopy (UB-92) without the RIN and HFS will assist in assigning a correct RIN to the claim in order to process it. As soon as system changes are in place to electronically process IDOC claims all providers will be notified and the hard copy claim process will end. Hospital providers will then utilize their current system of billing.

It is the intent of HFS and IDOC to expedite payment for services rendered to IDOC inmates. It is the intent to cycle for payment once a month, all clean claims received during the month for IDOC inmates. This should allow for an average payment cycle of approximately 30 days.

Your patience and participation with this interim process is greatly appreciated.

Please mail your completed bills to (and direct any questions to):

Healthcare and Family Services
Attn: Don Jenkins
Bureau of Rate Development and Analysis
201 South Grand Ave. East, 2nd Fl.
Springfield, Illinois 62763-0001

PH: 217-785-0710

RETURN WHEN SUBMITTING BILL TO HFS FOR PAYMENT
(To be completed by IDOC prior to arrival)

Date of Service: 6-23-08

Inmate Name (As provided by IDOC Staff):

Sheld, Ernest / BGD/C

SSN (if known): N/A



NOV 16 2008 10:00 AM 31
 4:00 PM 2008 5:53 PM

LAUNDRY
 (Radio 108) Allaga Hospital

STATIONARY LEAFLET (PS)

PAGE: 1 of 1

50.5047 P. 2

Diagnosis: 5254022
 Name: WHITMAN, ALAN
 Sex: M / DOB: 1/18/58
 Age: 50
 Race: W
 Ethnicity: N
 Date: 11/16/08
 Time: 10:00 AM
 Location: 1000

Ordering Dept: REP
 Order Ref: 4/16/08 17:04
 Order Status: ORDERED
 Staff Ref: 4/16/08 17:04
 Request By: OPTIMIZER

TRANSPORT: N/A
 IV: N/A
 LHM: N/A
 SET: N/A



000418879

Order Phys: PHYSICIAN/PHYSICIAN
 Admit Phys: PHYSICIAN/PHYSICIAN
 Primary Phys: PHYSICIAN/PHYSICIAN
 Jacket #:

Last Exam Date:

200 MR-UPPER EXTREMITY

COMPLETE MR SAFETY FORM

SIDET: LEFT INVOLUTION: NONE

*Dr. Whitman right left
 heard pop
 limited ROM
 severe pain in joint*

*MRI (L) shoulder - moderate tendinosis
 or partial tear supraspinatus tendon
 otherwise
 S. Cabanero, MD*

20:00-01:00

*Faced & called
 to ER 10:08
 11-16-08*

MS P-C

Galesburg Cottage Hospital
695 North Kellogg Street
Galesburg, IL 61401

MRSA:

CONFIDENTIAL PATIENT

Advanced Directive: (Y/N) N

PATIENT DEMOGRAPHICS

Name: SHIELDS EARNEST D
Address: PO BOX 1327
GALESBURG IL 61401
Home Phone: (309)343-4212
Former Name:
Birth Place - State: IL
Parent/Spouse Name:
Parent/Spouse SSN:
Emergency Contact: HENRY HILL
Emergency Contact:
DOB: 02/19/1971
SSN: 777-77-7777
Religion: N
County: KNOX
Employer:
Work Phone:
Employer:
DOB:
Home Phone: (309)343-4212
Home Phone:
Age: 37
Sex: M
MR#: 000418894
Race: B
Marital Status: S
Occupation: INMATE B66161
Work Phone: (000) -
Work Phone: (000) -

GUARANTOR

Name: HENRY HILL
Address: PO BOX 1327
GALESBURG IL 61401
Home Phone: (309)343-4212
DOB:
SSN:
County:
Employer:
Work Phone:
Age:
Sex: M
Relation: GR
Occupation: INMATE B66161

INSURANCE

Plan #: 415 2
Plan ID: INMATE B66161
Group #:
Group Name: OP
Subscriber Name: SHIELDS EARNEST D
Employer Name:
Plan Name: WEXFORD HEALTH SOURCES
Plan Address: PO BOX 16471
PITTSBURGH PA 15242
Plan Phone: (412)937-8590
PT Rel: SELF
Employ Status: INMATE B66
Treatment #:
Financial Class: G
Verified Ins. Plans:
COB: Y
DOB: 02/19/1971
SSN:
Plan #: 0 0
Plan ID:
Group #:
Group Name:
Subscriber Name:
Employer Name:
Plan Name:
Plan Address:
Plan Phone:
PT Rel:
Employ Status:
Treatment #:
COB:
DOB:
SSN:
Plan #: 0 0
Plan ID:
Group #:
Group Name:
Subscriber Name:
Employer Name:
Plan Name:
Plan Address:
Plan Phone:
PT Rel:
Employ Status:
Treatment #:
COB:
DOB:
SSN:

REGISTRATION

Admitting Physician: 817 BOMMIASAMY VEERASIKKU MD
Attending Physician: 817 BOMMIASAMY VEERASIKKU MD
Primary Care Physician: 0
Diagnosis 1: SHOULDER INJURY
Diagnosis 2:
Procedure:
Complaint:
Accident Onset Code:
Accident Place:
Comments: DCNDT

Order Exp. Date:
Accident Onset Date/Time:

Med/Champus Imp. Msg:
Adm. Priority:
Adm. Source: 7

MSP Quest:
Pt. Accom Type:
Pt. Service EOP

ABN:
SMN Status:

Private Room Arrangement:
Valuables:
Envelope #:

Patient Room:
Patient Unit or Station:

Arrival Date: 06/16/08 15:00
Registrar: MLD

Last D/C Date: 06/16/08
Patient Number: 5290082



>>>> 000418894

5290082

EOP

06/16/08

15:00

DATE PRINTED: 06/16/08

80

05 **Shoulder Injury (4)**

TIME SEEN: 3:00 PM ☐ on arrival ROOM: 8 EMS Arrival

HISTORIAN: patient spouse paramedics *PH 3000*

HX / EXAM LIMITED BY:

HPI

chief complaint: injury to right/left shoulder arm neck

duration / occurred:
just prior to arrival
today
yesterday
_____ days ago

where:
home
neighbor's
work
school
park
street

severity of pain:
mild moderate severe
worse / persistent since
pain intermittent / lasting

context: fell direct blow dislocated while raising arm

*11:50 AM - 12:00 PM
on right arm this morning*

associated symptoms: tingling / numbness diaphoresis
shortness of breath

ROS neck pain blow to head chest pain head / neck injury
other

PAST HX negative AK / D / HANDED prior injury
diabetes Type 1 Type 2 diet / oral / insulin

Meda- none / see nurses note

Allergies- NKDA / see nurses note

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed ☐ Tetanus Immun. UTD
VS BP 100/60 HR 100 RR 18 Temp 98.6

PHYSICAL EXAM

General Appearance c-collar (PTA / in ED) / backboard
no acute distress
alert mild / moderate / severe distress
anxious

SHOULDER
normal inspection
full ROM
no dislocation
see diagram
tenderness soft-tissue / bony
swelling
ecchymosis
deformity
clavicular deformity AC drop-off
anterior fullness
limited ROM
held in adduction abduction
internal rotation external rotation
limited adduction abduction
internal rotation external rotation
flexion extension

UPPER EXTREM.
uninjured below
shoulder
see diagram
tenderness soft-tissue / bony
swelling
limited elbow ROM



T-Tenderness PIT-Point Tenderness S-Swelling E-Ecchymosis B-Burn
C-Contusion L-Laceration A-Abrasion M-Muscle spasm PW-Puncture Wound
(C-w/without wound M-moderate S-severe)
Example: For Tenderness on palpation (nerve)

NEURO
sensation intact
motor intact
sensory / motor deficit
weak arm abduction (deltoid)
abnormal reflexes

VASCULAR
no vascular compromise
abnormal color / warmth / cap refill
brachial pulse deficit
radial pulse deficit

SKIN
warm, dry
see diagram
diaphoretic / cool / cyanotic

HEAD / ENT
oral inspection
pharynx nml

tenderness
swelling
ecchymosis

NECK / BACK

oral inspection
non-tender
painless ROM

tenderness
swelling
ecchymosis
vertebral point-tenderness

RESPIRATORY

chest non-tender
no resp. distress
breath sounds nml

tenderness
ecchymosis / abrasions
crepitus / subcutaneous emphysema
wheezes / rales / rhonchi

CVS

heart sounds nml
rate & rhythm

tachycardia / bradycardia

ABDOMEN

non-tender
no organomegaly

tenderness
guarding

PROCEDURES

REDUCTION OF SHOULDER DISLOCATION

- ☐ IV sedation
☐ Traction / Counter Traction
☐ Kocher maneuver
☐ Weights (lbs)
☐ Scapular manipulation
☐ Other
☐ See Conscious Sedation Sheet

RAYS ☐ Interpret by me ☒ Reviewed by me ☐ Discussed w/ radiologist

R/L Shoulder Clavicle

normal / NAD
normal alignment
no fracture
normal soft tissue

shoulder dislocation (anter/poster)
AC joint separation 1° 2° 3°
fracture non-displaced displaced
clavicular Hill-Sachs humeral
transverse oblique comminuted angulated
impacted

ther study:

See separate report

POST-REDUCTION X-RAY

normal (anatomic position)
reduced Hill-Sachs fx

CHECK POST-REDUCTION:

et
t somnolent

HER

g / shoulder immobilizer / clavicle strap

er

PROGRESS

Time ~~unchanged~~ improved re-examined

[Handwritten signature]

[Handwritten signature]

Rx given

referred to / discussed with Dr. Time

will see patient in: ED / hospital / office in days

CLINICAL IMPRESSION Fall Alleged Assault

Contusion / Hematoma / Sprain / Strain / Laceration

R/L shoulder forearm wrist
arm elbow hand

Fracture R/L clavicle scapula humerus head / neck / shaft
stabilized / restorative

Shoulder Separation R/L 1st 2nd 3rd degree

Dislocated Shoulder R/L anterior posterior

Rotator Cuff Tear

[Handwritten signature]

DISPOSITION: ☐ home ☐ admitted ☐ transferred

Time

CONDITION: ☐ unchanged ☐ improved ☐ stable

☐ Dictated Addendum

☒ Template Complete

MD / DO

SHIELDS EARNEST D

Patient #: 529062 HSV: EOP

Adm date: 2008-06-16 Medical Rec#: 418894

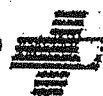
Adm Dr.: SOMMASAMY VEERASAKKUND

DOB: 1971-02-19 Age: 37 Sex: M

PATIENT NAME

O.P. NUMBER

DATE



Galesburg Cottage Hospital

696 N. Kellogg Street • Galesburg, IL 61401 • 309-343-8131

FOLLOW UP INSTRUCTIONS

- ☐ Follow-up & Re-evaluation in _____ Hours, _____ days, _____ weeks.
- ☐ Call for appointment.
- ☐ Appointment has been made for _____
- PHYSICIAN _____
- ADDRESS _____
- PHONE _____
- ☐ OP Tests _____

- ☐ Call your MD's office in 72 hours for your final culture report.
- ☐ X-rays do not always show injury or dislocation, and fractures may not be revealed on the initial x-rays. If the problem persists or worsens, additional x-ray or tests may be required. If this occurs, you should contact your physician or return to the ER. Your initial x-ray reading is a preliminary report. The radiologist will make a final reading. You will be informed if there is any significant difference from the preliminary reading.
- ☐ For Workers' Compensation patients see company MD within 24 hours for follow-up.

The physician services in the Galesburg Cottage Hospital Emergency Department are provided by Advanced Emergency Specialists, an independent contractor. The physicians constituting this group are not agents or employees of Cottage Hospital. The examination and treatment you have received in the Emergency Department has been rendered on an emergency basis only, and is not intended to be a substitute for, nor an effort to provide complete medical care. Because it is impossible to recognize and treat all elements of an injury or illness in a single emergency visit, it is important that you follow-up with your physician or the referral physician for your safety. Follow the instructions outlined below. If your present condition persists or worsens please contact the physician listed below. If unable to contact this physician you may return to the Emergency Department at any time.

PROVISIONAL DIAGNOSIS

Handwritten: R. 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

OTHER SPECIFIC INSTRUCTIONS

Handwritten: SLING To face 100% 11-31-1998

IT IS VERY IMPORTANT FOR YOU TO FOLLOW-UP AS DIRECTED, ESPECIALLY IF YOUR CONDITION PERSISTS, OR WORSENS, OR YOU DEVELOP NEW SYMPTOMS.

I HEREBY ACKNOWLEDGE RECEIPT OF AND UNDERSTAND THE PRINTED AND VERBAL INSTRUCTIONS.

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON

Handwritten: Carla Sobber

SIGNATURE OF NURSE

Handwritten: 1900

GENERAL INSTRUCTIONS

- Persistent pain or disability for more than 72 hours are caution signs; notify your physician for further evaluation.
- ☐ Your eye has been patched. Please remove the patch in _____ hours. DO NOT DRIVE, as your ability to perceive depth will be impaired and your field of vision restricted.
- ☐ Ace/Splint
- ☐ Keep injured part at rest and elevated as much as possible.
- ☐ Ice intermittently to injured area for 24 hours. (On for 20 minutes then off for 20 minutes, etc.) Place cloth between ice bag to protect skin.
- ☐ Use head.
- ☐ No weight bearing until okayed by your main physician, use crutches as directed.

MEDICATIONS

- ☐ Medications per reconciliation process.
- ☐ Due to medication you have been given in the emergency department, your reactions may be impaired and you may be drowsy. Do not drive, operate potentially dangerous machinery, or climb heights for 8 hours.
- ☐ Ibuprofen (Motrin, Advil) Adults: _____ milligrams, # _____ every _____ hours. Please stop ibuprofen if you should develop abdominal pain, blood in your stools or black stools. DO NOT USE IF ALLERGIC.
- ☐ Acetaminophen (Tylenol) Adults: _____ milligrams, # _____ every _____ hours. DO NOT USE IF ALLERGIC.

WOUND CARE INSTRUCTIONS

- Follow-up with your own MD within 1 to 2 days for wound check. Call for appointment.
- ☐ Keep dressing clean and dry.
- ☐ Observe for signs of possible infection which include: Redness, swelling, heat, red streaks, pus and/or drainage, increased pain, unexplained fever. CONTACT YOUR DOCTOR IMMEDIATELY IF THESE OCCUR.
- ☐ Arrange for suture removal in _____ days.

SPECIAL CARE INSTRUCTIONS

- ☐ Drink lots of cool fluids, water and juices etc. # Dances _____ Per _____
- ☐ Take temperature every 2 - 4 hours.
- ☐ Extra rest.
- ☐ Call physician immediately if seizures or convulsions occur or if a rash develops.

ADDITIONAL NOTES (Nurse)

- | | | |
|--|---|--|
| <input type="checkbox"/> Colds/flu, sore throat, cough | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Otitis Media Sheet |
| <input type="checkbox"/> Orthopedic injury care | <input type="checkbox"/> Back pain | <input type="checkbox"/> Animal Bite Sheet |
| <input type="checkbox"/> STD instructions | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Immunization Card Given |
| <input type="checkbox"/> Burn Care | <input type="checkbox"/> Heat and Cold emergencies | <input type="checkbox"/> |
| <input type="checkbox"/> Respiratory care, cough, asthma | <input type="checkbox"/> Vomiting/diarrhea in adults | <input type="checkbox"/> |
| <input type="checkbox"/> Fever & chills instructions | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> |
| <input type="checkbox"/> Head Injury Sheet | <input type="checkbox"/> Diets | <input type="checkbox"/> |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> General pediatric instructions | <input type="checkbox"/> |
| <input type="checkbox"/> Post Nosebleed information | <input type="checkbox"/> Fever/Med Sheet | <input type="checkbox"/> |

Form # 0600173 (Rev. 3/00)

Galesburg Cottage Hospital
309-343-8131

696 N. Kellogg St.
Galesburg, IL 61401

FOR *Handwritten: SHISC DISCHARGE* DATE *Handwritten: 6/1/98*

ADDRESS _____
Fax _____

Galesburg Cottage Hospital
309-343-8131

696 N. Kellogg St.
Galesburg, IL 61401

FOR _____ DATE _____
The above was seen, treated, and released from our Emergency Department. I recommend:

- ☐ Release from usual/all employment responsibilities for _____ days.
- ☐ Release from participation in school classes/physical education / athletics for _____ days.
- ☐ Immediate return to work/school.
- ☐ Restrictions: _____

M.D.